COUNTY MEDICAL SERVICES PROGRAM
1800 THIRD STREET, ROOM 100
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 322-1478

A County-State
COUNTY MEDICAL SERVICES PROGRAM
CMSP
Partnership in Health Care

CMSP Letter : 01-6
Issue Date : October 12, 2001

TO: ALL COUNTY MEDICAL SERVICES PROGRAM
WELFARE DIRECTORS

SUBJECT: VERIFICATION OF FISCAL YEAR (FY) 2000-01
ELIGIBILITY EXPENDITURES

The purpose of this letter is to request verification of County Administrative Costs associated with the County Medical Services Program (CMSP) eligibility process. Enclosed is a spreadsheet listing CMSP eligibility expenditures by county for FY 2000-01.

If your county has submitted adjusted supplemental Administrative Cost Claims that impact the CMSP, it is likely that they are not reflected in these data. Such claims will be considered if you complete and return the enclosed "CMSP Amended Eligibility Expenditures Report" by December 31, 2001. Please note that any supplemental claims filed after December 31, 2001, cannot be considered. This form must also be used to provide "corrected" information from the original Administrative Cost Claim submitted for each quarter.

Please be aware that the final allocations will be subject to review by the Eligibility Committee and final approval by the CMSP Governing Board. At the present time the CMSP budget for eligibility expenditures is set at $15.2M; with the current annual program deficit, it is not anticipated that there will be any increase in this figure.

If you find that the information for your county is correct, there is no need to take any further action. If additional or corrected information is identified, please send the completed report to:

Office of County Health Services
County Medical Services Program
Attention: Ms. Tina Thomas
1800 3rd Street, Room 100
P.O. Box 942732
Sacramento, CA. 94234-7320

The reports may also be faxed to (916) 323-3350. If you have any questions regarding this report, please contact Ms. Thomas at (916) 327-4842.

Gail Winter, Chief
County Medical Services Program

Enclosures

cc: Ms. Tina Thomas
County Medical Services Program
Department of Health Services
1800 3rd Street, Room 100
P.O. Box 942732
Sacramento, CA 94234-7320

CMSP ELIGIBILITY EXPENDITURES
STATE FISCAL YEAR 2000-2001
Prepared by: Tina Thomas 10/4/01

COUNTY	1ST QTR	2ND QTR	3RD QTR	4TH QTR	TOTAL
Alpine	$31,592				**$31,592**
Amador		$32,821	$34,808	$35,860	**$103,489**
Butte	$211,997	$226,836	$213,497	$296,106	**$948,436**
Calaveras	$23,753	$21,113			**$44,866**
Colusa	$20,980	$24,056	$30,284		**$75,320**
Del Norte	$25,068	$40,568	$38,173	$43,647	**$147,456**
El Dorado	$182,085	$189,222	$213,426	$174,119	**$758,852**
Glenn	$29,761	$48,074			**$77,835**
Humboldt	$203,291	$259,145	$239,044	$282,522	**$984,002**
Imperial	$200,565	$196,236	$259,687	$303,843	**$960,331**
Inyo	$28,429	$52,384	$30,162	$43,572	**$154,547**
Kings	$84,443	$111,516		$89,456	**$285,415**
Lake	$64,694	$53,199	$84,282	$102,970	**$305,145**
Lassen	$39,411	$19,734	$33,204	$27,744	**$120,093**
Madera		$118,408	$146,336	$172,801	**$437,545**
Marin	$199,018				**$199,018**
Mariposa	$26,074	$35,662	$27,132	$27,055	**$115,923**
Mendocino				$327,880	**$327,880**
Modoc					**$0**
Mono	$29,193	$51,328	$38,923	$29,689	**$149,133**
Napa	$157,517	$184,888	$134,686	$115,123	**$592,214**
Nevada					**$0**
Plumas	$13,942		$12,376	$21,329	**$47,647**
San Benito	$29,945	$37,183	$40,506	$40,149	**$147,783**
Shasta	$274,488	$289,528	$294,112	$252,239	**$1,110,367**
Sierra	$3,147		$2,613	$1,263	**$7,023**
Siskiyou	$85,305	$66,630	$62,609	$73,821	**$288,365**
Solano	$440,255	$468,260	$464,355		**$1,372,870**
Sonoma					**$0**
Sutter	$78,999	$74,766	$128,380	$50,656	**$332,801**
Tehama	$86,715	$87,045			**$173,760**
Trinity	$13,657	$15,603			**$29,260**
Tuolumne	$90,830	$86,020	$101,125	$89,187	**$367,162**
Yuba	$81,951	$130,473			**$212,424**
TOTAL	**$2,757,105**	**$2,920,698**	**$2,629,720**	**$2,601,031**	**$10,908,554**

COUNTY MEDICAL SERVICES PROGRAM
AMENDED ELIGIBILITY EXPENDITURE REPORT
FOR THE STATE FISCAL YEAR 2000-01

QUARTER:_____

AMOUNT FROM DHS WORKSHEET $_____

CORRECTED AMOUNT $_____

SUPPLEMENTAL CLAIM DATE:_____

SUPPLEMENTAL CLAIM AMOUNT $_____

REVISED TOTAL FOR THIS QUARTER $_____

QUARTER:_____

AMOUNT FROM DHS WORKSHEET $_____

CORRECTED AMOUNT $_____

SUPPLEMENTAL CLAIM DATE:_____

SUPPLEMENTAL CLAIM AMOUNT $_____

REVISED TOTAL FOR THIS QUARTER $_____

I certify under penalty of perjury that the amounts shown above are correct and accurately reflect the information, which has been submitted to the State Department of Social Service on regular and supplemental (adjusted) Administrative Cost Claims.

_____ _____ _____
(Printed Name/Title) (Signature) (Date)